IMPLEMENTING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) IN ILLINOIS –

RECOMMENDATIONS OF

THE ILLINOIS HOSPITAL ASSOCIATION

December 3, 2010

IMPLEMENTING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) IN ILLINOIS - RECOMMENDATIONS OF THE ILLINOIS HOSPITAL ASSOCIATION

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Executive Summary

The Illinois Hospital Association (IHA) and its 200 member hospitals and health systems recognize the unprecedented opportunities the Patient Protection and Affordable Care Act (ACA) offers to reform the way health care is delivered, paid for, and experienced in this state. This document summarizes IHA's key recommendations for state implementation of the ACA.

A. Blueprint for an Illinois Health Insurance Exchange "Improving Coverage – Building on Strengths"

Guiding Principle: *All Illinois residents should have access to quality health care and all eligible individuals should be enrolled in a health plan or program.*

One of the most significant provisions of the ACA is the requirement for states to establish an insurance Exchange - a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage. IHA recommends that the state start small by focusing first on the mechanics of providing an efficient private health insurance marketplace for consumers. In addition, it is important to build on and strengthen those areas of the system that are currently established to support the oversight of the insurance and health care delivery industries that will be affected by the Exchange. Recommendations include the following:

- **Meet the January 1, 2014 deadline** for establishing a state insurance exchange, after which the formation of the Exchange defaults to the federal government.

- **Establish the Exchange governance.** While IHA has not dismissed the idea of housing the Exchange in an existing department, we support the establishment of an Exchange as an autonomous state agency, more independent than, but similar to the Illinois Comprehensive Health Insurance Plan (ICHIP) with a specifically defined board representing key stakeholders and a director with a set term of service.

- **Avoid rate setting.** While "bending the cost curve" is an important consideration, the Exchange should not engage in any form of rate setting as a cost containment tool. We also believe the rate review function should continue to be undertaken by the Department of Insurance.

Additional suggestions are to **combine oversight functions under the Illinois Department of Insurance; limit enrollment periods** to minimize adverse selection; and **ensure continuity of care** among applicants who may move between Medicaid and private insurance.

B. Medicaid Reform

Guiding Principle: *All eligible individuals in Illinois should be enrolled in a health plan or program; payment for health care services should be fair and timely; include consideration for time spent on care management and coordination of care among a patient's various providers; and reward appropriate care outcomes that are delivered in a cost-effective manner.*

The ACA calls for a major expansion of Medicaid to cover all people with incomes up to 133 percent of the Federal Poverty Level (about $14,000 for an individual or $30,000 for a family of four). In Illinois, that means about 700,000 more people will be potentially eligible for Medicaid, an enrollment increase of more than 25 percent. As the Council considers strategies and reforms for the Medicaid program, we urge you to "first, do no harm" to patients and the health care delivery system. We urge you to review what is working well and build on those approaches, and test out new strategies through pilot and demonstration projects before considering their implementation on a wider scale. Recommendations include the following:

- **Pursue Medicaid demonstration projects and grants,** to enable providers to develop the infrastructure needed to fundamentally restructure the Medicaid program toward accountable, value-based care.

- **Pursue expanding Medicaid eligibility for populations currently covered solely by state funds.** For example, integrate behavioral health care with primary medical care to make behavioral health services available to a wider population – especially to single adults without children and obtain federal Medicaid matching funds to help pay for those services.

- **Enhance primary care case management and disease management programs** to include additional populations, conditions, and providers.

- **Maximize federal funding for Medicaid in the short-term and long-term.** Continue efforts to maximize claims for federal Medicaid reimbursement for as many qualifying services as possible, now through the end of June, 2011, under the state's enhanced federal matching rate (FMAP).

C. Incentivizing Delivery System Reforms to Improve Quality and The Use of Health Information Technology

Guiding Principle: *The regulatory environment must allow clinical and financial integration of health care entities; promote health care professionals working together in teams; and provide for implementation of efficiencies that reduce cost while maintaining quality.*

The ACA offers many opportunities for piloting innovative approaches to health care delivery that are designed to realize savings, including medical homes, bundled payments, and the Accountable Care Organization (ACO). Health information technology (HIT) can enhance each new approach. Key recommendations on delivery system innovations and HIT include:

- **Reinvest savings in health care** to further improve access to quality health care, especially for the substantial number of persons who will not be covered by the expansion of Medicaid.

- **Allow flexibility.** Because hospitals are key economic engines for Illinois communities, it is critical during this transition, that hospitals have flexibility to sustain current operations, while simultaneously taking steps to re-align, integrate with other providers, and better coordinate care.

- **Foster ability to form or join systems of care.** State regulations should allow for new business arrangements among health care providers, and new payment mechanisms. This may require amendment of current rules governing the relationships among providers.

- **Work toward consistency among federal, state and private payors.** Incentives and approaches adopted by the state should be consistent with approaches adopted by the federal government and private payors.

Health Information Technology

- **Ensure the HFS plan for Medicaid electronic health record (EHR) incentives is submitted in January 2011** so EHR funding is available in the spring.

- **Request that federal funds be available for hospital systems** that operate multiple hospitals under a single payer identification number and that behavioral health, rehabilitation, and long-term acute care hospitals be afforded the same incentive plans to implement EHRs and Health Information Exchanges (HIEs).

- **Appoint the HIE Authority's directors** as soon as possible so HIE plans can advance.

D. Health Care Reform and Workforce Development and Retention

Guiding Principle: *The state of Illinois must have an adequate number of health care professionals to provide for the health care needs of its residents, and a sound plan to meet future health care workforce needs.*

Key to the goals of health care reform is developing and sustaining an adequate number of qualified health care professionals to provide a range of health care services across the state. Recommendations include:

- **Explore approaches and eliminate barriers** to allow for the expanded use of advanced practice nurses and physician assistants.
- **Expand the Illinois Center for nursing initiative** to add physician workforce data.

- **Develop an ongoing Illinois physician profile** that includes the practice retention rate for Illinois medical education graduates, retirement projections, and other demographic data.

- **Support medical education requirements** that incorporate incentives to encourage retention of qualified physician graduates in Illinois.

- **Support pilots and other efforts to recruit and retain medical students**, physicians and mid-level providers who will practice in rural, underserved and shortage areas.

Conclusion

IHA and the hospital community are strongly committed to their partnership with the state to both sustain the health care delivery system in the short term and to transform it in the long term. During the transition, the state must take a balanced and thoughtful approach to implementing health care reform, with vigorous and widespread input by all affected parties. We look forward to putting Illinois on the map as a premier state for health care quality and patient safety as well as working with the state to create sound public policy facilitating tomorrow's supply of qualified and participating health care professionals.

Hospitals are well-positioned to partner with the state to build on current mutual strengths as we move forward with reform. IHA is committed to supporting the state's compliance with the ACA and efforts for a successful transition to what can be a revolutionary system of health care delivery, payment, and patient experience in this state.

IMPLEMENTING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) IN ILLINOIS - RECOMMENDATIONS OF THE ILLINOIS HOSPITAL ASSOCIATION

December 3, 2010

The Illinois Hospital Association (IHA) and its 200 member hospitals and health systems recognize the unprecedented opportunities the Affordable Care Act (ACA) offers to reform the way health care is delivered, paid for, and experienced in this state. At the same time, we realize the ACA presents Illinois with tremendous challenges that will affect consumers, employers, insurers and health care providers in ways that will evolve over the next several years. Many of these changes are currently undefined, due to the fact that the ACA places significant policy decisions in the hands of the Secretary of the U.S. Department of Health and Human Services (Secretary), the National Association of Insurance Commissioners (NAIC), and the states. At the state level, responsibility for crafting methods and systems that will realize the aims of health care reform - to increase access, control costs, and improve quality - must be shared by all stakeholders.

Hospitals' Impact in Illinois

Just as the state of Illinois has a diverse tapestry of residents, there is no "typical" Illinois hospital. Eighty-seven of the state's two hundred hospitals are small or rural and include fifty Critical Access Hospitals that weave a safety net across scattered rural communities. At the opposite end of the spectrum are the large urban academic medical centers that attract patients worldwide; and in between, community hospitals that offer a rich variety of services, including local centers of excellence focusing on specific disease conditions, long-term care, home health services, and much more. But hospitals represent more than a source of care 24 hours a day, seven days a week, 365 days a year.

While fulfilling our missions as health care providers, hospitals are a force for economic growth for our communities and the state. Currently, Illinois hospitals directly employ over 255,000 people, with each job supporting an additional 1.1 jobs in other businesses and industries. Every dollar that hospitals spend on goods, services and payroll, generates an additional $1.40 in spending throughout the state and results in a total annual impact of $75.1 billion on the state's economy. In addition, hospitals have

partnered with the state to bring in billions of dollars in federal funds for the Medicaid program, through the Hospital Assessment Program, which also significantly benefits non-hospital providers.

Why are these "dual roles" of hospitals important to the implementation of health care reform? The reason is that critical decisions about reforming the health care system must involve a deliberative process with all stakeholders, so the important roles that hospitals play will not be inadvertently diminished, to the detriment of all Illinoisans. Therefore, we preface our recommendations with the following principles that we believe should guide the deliberations around health care reform implementation in Illinois:

Principles for Health Care Reform Implementation

1. All Illinois residents should have access to quality health care at the right time, in the appropriate setting, across the spectrum from preventive to end-of-life care.

2. Individuals should take responsibility for maintaining a healthy lifestyle, and have opportunities for exercise, a nutritious diet, and other preventive measures.

3. Payment for health care services should be fair and timely; include consideration for time spent on care management and coordination of care among a patient's various providers; and reward appropriate care outcomes that are delivered in a cost-effective manner.

4. All eligible individuals in Illinois should be enrolled in a health plan or program, and stakeholders must work to address payment for care to those who are ineligible.

5. The state of Illinois must have an adequate number of health care professionals to provide for the health care needs of its residents, and a sound plan to meet future health care workforce needs.

6. The regulatory environment must allow clinical and financial integration of health care entities; promote health care professionals working together in teams; and provide for implementation of efficiencies that reduce cost while maintaining quality.

7. Responsibility for the successful implementation of health care reform in Illinois is shared by providers across the spectrum of health care; government; business; the insurance industry, and individual residents.

The following four sections present the views of the Illinois Hospital Association on the topics of insurance reforms and the state insurance exchange; Medicaid reform; delivery system reforms and health information technology; and workforce development and retention.

A. Blueprint for an Illinois Health Insurance Exchange "Improving Coverage – Building on Strengths"

One of the most significant provisions of the Patient Protection and Affordable Care Act (ACA) is the requirement for states to establish an American Health Benefit Exchange and a Small Business Health

Options Program Exchange (Exchange). The purpose of the Exchange is to make qualified health plans available to qualified individuals and qualified employers thereby not only expanding consumers' access to health insurance coverage, but also allowing consumers the opportunity to choose health plans that fit their needs. The creation of an Exchange, however, will significantly alter the commercial insurance marketplace as well as modify how consumers access coverage for medical care.

IHA has consistently recommended that in establishing an Exchange, regardless of its final form, there needs to be a balance between the need to ensure that the Exchange meets minimum federal requirements and the need for state flexibility – enough flexibility for Illinois to design and implement the Exchange to suit the unique needs of the state's population and health delivery systems. In developing a workable, flexible system of health care coverage through an Exchange, IHA recommends that the state start small by focusing first on the mechanics of providing an efficient private health insurance marketplace for consumers. In addition, it is important to build on and strengthen those areas of the system that are currently established to support the oversight of the insurance and health care delivery marketplace that will be affected by the Exchange. In so doing the state will be able to ensure that the responsibilities of the Exchange do not duplicate functions of existing state agencies, protect against the inefficient use of limited state resources, and allow the dynamics of a competitive insurance market to flourish under the constraints and consumer protections established under the ACA. Our specific recommendations are discussed in detail below.

Recommendations Related to the Insurance Exchange

State Control

The ACA establishes deadlines that the states must meet in order to create a state-run Exchange. The most important of these is January 1, 2013, at which time the state must elect to establish its own Exchange. Absent specific state action to form an exchange by January 1, 2013, the Secretary has the authority to determine that the state will not have an Exchange operational by January 1, 2014 or that the state has not taken the actions the Secretary determines necessary to implement an Exchange. If the Secretary makes such a determination, the authority for establishing an Exchange would default to the federal government.

IHA believes that it is incumbent on the state to both elect to establish an Exchange and to ensure appropriate steps have been taken to ensure the Exchange will be operational by January 1, 2014. Allowing the establishment of an Exchange to default to the federal government would not be in the interest of Illinois citizens. Such action would make it difficult for the Exchange to recognize the nuances of state-specific markets, reduce the likelihood of meaningful stakeholder involvement in Exchange decisions, and lead to possible conflicts with existing state programs and regulations relating to the regulation of insurance plans and the administration of the state's Medicaid program.

Exchange Governance

Once a state determines to establish an Exchange, the ACA leaves it to the state to establish the form of governance of the Exchange, provided the Exchange is established as a governmental agency or nonprofit entity that is established by a state. While IHA has not dismissed the idea of housing the Exchange in an existing department and would actively work to ensure its efficient operation within a departmental structure, IHA supports the establishment of an Exchange as an autonomous state agency, more independent than, but similar to the Illinois Comprehensive Health Insurance Plan (ICHIP) with a

specifically defined board representing key stakeholders and a director with a set term of service. Not only would such governance maintain stability and neutrality during political change, it would also allow other key agencies, such as the Department of Healthcare & Family Services (DHFS), the Department of Insurance (DOI), and the Department of Public Health (DPH), to continue to focus on their existing duties and responsibilities. Free of the diversions of balancing Exchange duties with existing Department responsibilities that would be inescapable if the Exchange were formed within an existing state agency, such a governing board would be in a position to focus its attention on its primary mission: to create a competitive marketplace for consumers to purchase coverage while ensuring that existing access to Medicaid and other public programs is not disrupted.

IHA recommends that the governing board of the Exchange should be broadly defined with a sufficient number of board members to encompass a diverse variety of stakeholders including health care advocates and providers. Within such a construct, the directors of affected state agencies should serve as ex officio members on the board. Stakeholders in the insurance industry, including insurance companies and brokers, should be provided access to the decisions of the board through the establishment of an appropriate number of advisory boards to ensure undue influence is not exerted by special interests.

Once the Exchange is established as an autonomous entity, the state should work to ensure the Exchange has enough flexibility in hiring and procurement practices to ensure the retention of an appropriately professional workforce with the tools necessary to function professionally in an ever complex electronic market. Some states have enacted legislation that free the Exchange from state hiring requirements and procurement practices. We would hope that such steps would not be necessary. However, given the very strict time frames established by the ACA, getting bogged down in the lengthy process to establish and fill state employee positions and to have contracts and purchases approved through existing state procurement and contracting requirements might be tantamount to defaulting to federal control of the Exchange.

Functions of the Exchange

Once established, the ACA sets out specific duties to be performed by the Exchange. But the ACA also leaves many of the functions of the Exchange undefined leaving it up to the state to determine how much or how little authority the Exchange will have, both in how the Exchange market is formed and how the Exchange is administered. While it might be possible to establish an Exchange that could perform all of the required and optional functions that would be necessary for the Exchange to act as a purchaser of services, such as the Massachusetts and California models, given the state's limited assets IHA believes that the Exchange should allow the market and a plan's self-assessment be the determinant of whether a plan participates in the Exchange. Given the lack of familiarity with acting as a purchaser of insurance, the Exchange should not overreach in this area. At least at the outset, plans should be encouraged to participate in the Exchange, thereby increasing plan options for employers and consumers. Similarly, in terms of administrative functions relating to the payment and distribution of premiums, coordination of records, etc., IHA would urge caution in assuming the burden of these optional duties. Given the state's economic condition and the requirement that the Exchange become self supporting by 2015, overstepping in areas that could prove costly once the Exchange is running would be inadvisable, particularly considering the additional concern of how assuming such functions might adversely affect the market.

- **Qualified Health Plans.** While the federal law requires the Secretary to establish the criteria for qualified health plans that can be offered in the Exchange, the Exchange is to implement procedures for the certification, recertification, and decertification of health plans as qualified health plans consistent with guidelines developed by the Secretary. The IHA recommends that the Secretary and Exchanges allow for a manageable range of plans to qualify for the Exchange, including local health plans such as those offered by some hospital and physician-based integrated health systems. In establishing certification requirements, the state should establish criteria broad enough and consistently applied to create a competitive environment within the Exchange and to better facilitate plan oversight, without allowing individual insurers to flood the Exchange with a large number of plans that have only minor differences.

- **Rate Oversight/Cost Containment.** A key aspect of the ACA was to put more power in the hands of the states to oversee how insurers establish rates and regulate the percentage of premium devoted to clinical services and health care quality improvement activities. In so doing, the ACA provided that the Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. While "bending the cost curve" is an important consideration, the Exchange should not engage in any form of rate setting as a cost containment tool. Establishing artificial rates could have significant and unanticipated effects on the availability and delivery of health care. In particular, government rate setting often results in problems with consumers not being able to obtain adequate access to care. At a time when providers are facing significant downward pressure on costs for the delivery of care through public plans, IHA believes the established ability for plans and providers to negotiate reimbursement rates in the private market should be maintained. Rate setting would significantly affect that established system.

  IHA also believes the rate review function should continue to be undertaken by the Department of Insurance. While current Illinois law severely limits the DOI's ability to approve rates and rate increases, DOI has begun assuming greater oversight with the issuance of the Department's Company Bulletin 2010-08 which requires the submission and approval of actuarial memorandum and justification review standards for new and renewal health rates. Creating a separate review authority within the Exchange would be duplicative, costly and divert efforts within the Exchange from its prime function of facilitating enrolling uninsured individuals within an appropriate health plan.

- **Network Adequacy.** The ACA requires the Secretary to ensure by regulation, that network-based plans offer an adequate provider network, including community providers. IHA has recommended that the Secretary establish specific network adequacy criteria for qualified health plans. IHA further recommended that any quality measures the Secretary establishes for qualified health plans offered through the Exchanges should include network adequacy. Specifically, there needs to be a mechanism to ensure that a health plan has an adequate network and sufficient capacity to accept new patients both initially and throughout the plan year, similar to the network adequacy standards in place for Medicare Advantage. The establishment of such standards, however, will place a federal standard on state regulated plans and duplicate and possibly conflict with current state network-adequacy requirements. In establishing an Exchange, the state needs to be cognizant of such potential conflicts and work to ensure that the delivery of care is not compromised by divergences between state and federal regulations. Again, given that DOI and DPH already perform this function, it is more logical to

amend the existing mechanism to meet the new needs concomitant with health insurance reform than by establishing a duplicative mechanism of assuring network adequacy.

Of concern is the current bifurcated function of network approval in Illinois. While DPH performs this function for HMOs, DOI is responsible for network oversight of preferred provider organization networks. IHA recommends that all network oversight functions be combined under a strengthened oversight and review authority within the DOI, which otherwise has all regulatory authority over these two types of health coverage plans.

More specifically, there needs to be a mechanism to ensure that a health plan has an adequate network and sufficient capacity to accept new patients both initially and throughout the plan year. Health plans need to prove that consumers will be able to access necessary services at a reasonable distance and in a reasonable timeframe to address their particular health care needs. The criteria could include requiring health plans to submit encounter data to the Department to evaluate whether the enrollee is actually receiving services and is not being required to travel unreasonable distances to do so. Regular monitoring of adequacy by the Department would help ensure that plans are not operating "shadow" networks (networks that list providers but do not ensure they are accepting new patients under that plan).

- **Enrollment.** Beginning January 1, 2014, the ACA expands Medicaid eligibility to persons with incomes below 133% of poverty and establishes a mandate for individual coverage. In Illinois, IHA estimates that approximately 700,000 of the 1.9 million currently uninsured Illinoisans will become Medicaid-eligible, and an additional 330,000 individuals are expected to obtain commercial coverage. The challenges confronting the Exchange faced with this increased enrollment burden, particularly given the transitional interface between commercial enrollment and Medicaid enrollment, are daunting. The Exchange and hospitals are likely to bear the initial brunt of individuals seeking coverage with hospital emergency departments serving as one of the first points of entry into the health care system for many uninsured. Because of this, coordination between the Exchange and hospitals at the point of enrollment will be crucial.

  The ACA establishes that the Exchange is to inform individuals of eligibility requirements for Medicaid or CHIP through screening of the application by the Exchange and enroll individuals in those programs and, further, to grant a certification attesting that, for purposes of the individual responsibility penalty an individual is exempt from the individual mandate requirement. In order to accomplish the demands of enrolling this influx of individuals, the Exchange will need to have a sophisticated and current technology system. IHA has recommended that the Secretary should consider ways to assist states, such as the creation of federal electronic enrollment platforms that states could access, thereby eliminating the need to reinvent systems at the state level. The Exchange should take full advantage of national platforms to ensure a seamless enrollment process. Ensuring the utmost coordination between federal agencies and states with regard to enrollment information, including income data is a priority. IHA encourages the Exchange to consider the role hospitals and providers play helping patients identify and seek assistance for all types of health insurance coverage.

- **Enrollment Periods**. A chief concern of most stakeholders in the Exchange is the problem of controlling adverse selection. IHA recommends the Exchange should limit enrollment periods to minimize the potential for adverse selection. The ACA requires the Exchange to provide for an initial open enrollment, an annual open enrollment period, and special enrollment periods.

Given the potential for significant demand through an untested enrollment system on January 1, 2014, the initial open enrollment period should be long enough for the system to work through any problems and for individuals to be properly educated on the enrollment process. Because of the penalties involved and the potential benefits to be derived from inducing individuals to enroll, the system should be flexible enough to ensure qualified individuals are not disenfranchised. IHA would recommend an initial enrollment period of at least six months to take full advantage of providing coverage of uninsured individuals.

Similarly, annual open enrollment should be structured to ensure a narrow enough time frame to avoid adverse selection, where individuals wait to seek coverage until they are sick, while providing ample time for eligible persons to gain access to coverage. Currently Medicare's open enrollment period, when current and newly eligible beneficiaries choose their health and drug plan options, lasts for approximately six weeks from mid-November to the end of December. This can serve as template for Exchange open enrollment. However, one of the goals of the Exchange is to decrease the number of uninsured. To balance the concerns of adverse selection with the need to decrease the number of uninsured, IHA would recommend that the Exchange handle open enrollment through semiannual open enrollment periods; the first running from mid-May to the end of June with coverage becoming effective July 1. The second would run from mid-November to the end of December with coverage becoming effective January 1.

Special enrollment periods should be established that use the requirements established by HIPAA and state continuation requirements for group health plans as a platform, but tailored for persons losing prior individual coverage. Examples include when a dependent turns 26 and loses coverage under a parent's individual plan or when a spouse or dependent children lose coverage when the owner of an individual policy dies. In all instances, when the loss of coverage is due not to an election by the individual, but to circumstances beyond the enrollee's control, they should be afforded special enrollment rights.

- **Continuity of Care.** To ensure continuity of care among applicants who may move between Medicaid and private insurance provided through the Exchange, it will be critical for the state to establish consistent coverage standards and policies and reasonable provider rates for Medicaid. Benefit packages should be comprehensive and similar under Medicaid and private insurance provided through the Exchange. Uninsured individuals needing health services, whether through Medicaid or an Exchange health plan, should have similar coverage and similar access to providers. To achieve this goal, the Medicaid provider rates will need to be comparable to the provider rates negotiated by the private plans offered on the Exchange. However, given the importance of having an adequate network of providers, the state should be careful not to use Medicaid reimbursement rates, which are already low, as the floor for the rates in the Exchange. Inadequate rates would only discourage physicians from participating and result in challenges for Medicaid beneficiaries in finding primary care physicians, and even more difficulties, in finding specialists who will care for them.

  In addition, persons moving from Medicaid to an Exchange plan should be confident that they will be able to continue treatment with their existing health care provider. Current Illinois law already has protections for persons covered by an HMO who lose access to their provider due to the provider leaving the HMO's network. Section 25 of the Managed Care Reform and Patient Rights Act (215 ILCS 134/25) establishes time frames for continuing to see a provider under these circumstances given the provider's acceptance of various terms, including accepting the

plan's established applicable reimbursement rates. We believe that such transition language could be used as a starting point for drafting language that would help ensure continuity of providers when persons transitioning out of Medicaid into a commercial plan when the Medicaid provider is not part of the plan's network.

- **Navigator.** The ACA requires an Exchange to establish a program under which it awards grants to qualified entities to carry out defined education of individuals and facilitate enrollment in qualified plans. IHA recommends that hospitals wishing to act as navigators should be awarded such status. Hospitals generally meet the eligibility requirements that a navigator have existing relationships with employers, employees, consumers, or self-employed individuals likely to be qualified to enroll in a qualified health plan. These relationships already exist in most communities where hospitals are integral parts of the business community, have existing interaction with employers and individuals through current agreements, and often serve as the front line health care delivery systems for uninsured individuals.

  Hospitals also currently perform most of the duties enumerated in the act relating to the required duties of a navigator. Services currently performed by hospitals can easily be expanded to include educating individuals on qualified plan options, providing information on enrollment and premium tax credits, facilitating enrollment, referring individuals to the office of health insurance consumer assistance, and providing culturally and linguistically appropriate information to diverse populations.

  The ACA also establishes standards to ensure appropriate licensure and avoid possible conflict of interest including the prohibition on the navigator from receiving any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan. IHA fully supports these concepts and believes possible reimbursements from insurers for treatment of individuals does not fall into the category of receiving consideration for enrolling individuals. In order to ensure reimbursements for treatment and services are treated separately from enrollment considerations, IHA would support Exchange requirements that any navigator provide the establishment of a firewall between enrollment and payment functions in order to ensure enrollees receive unbiased recommendations.

Functions of Other Agencies

As mentioned throughout this Blueprint, it is imperative that the Exchange concentrate on its core duties while allowing other state agencies to continue to perform duties with which they are currently charged. Due to the unknown costs of the Exchange and the current budget crisis faced by the state, duplicating functions or creating unnecessary regulatory structures could derail what should be a prime opportunity to reduce the number of uninsured in Illinois. On the other hand, it will also be important to establish meaningful lines of communication between the Exchange, the DHFS, DOI and the federal government to ensure ease of enrollment, transition of coverage between commercial and public plans, competitive and fair market conditions particularly relating to rate oversight, etc.

For enrollees who qualify for Medicaid, DHFS will need to continue the seamless and timely enrollment of individuals both through traditional enrollment avenues, but also through Exchange and navigator enrollment. Coordination between DHFS and the Exchange to ensure that persons who qualify for

Medicaid find the same enrollment environment regardless of which path they apply for coverage will be a challenge.

Likewise, DOI should continue its responsibilities to approve policy filings expanded to include filings and certifications of qualified health plans. Qualified health plan approval should be given priority status in the DOI approval process to ensure coverage for the emerging Exchange market. Similarly, the financial review of plans in the Exchange, including assessment of medical loss ratio standards and premium oversight, should be given primary status in the DOI review process. Finally, network adequacy requirements for plans, both in the Exchange and sold in the commercial market, should be delegated to the DOI.

Conclusion

The difficulty in dealing with all of these variables in light of what are due to be widely divergent interests among stakeholders is inescapable. What IHA proposes is that the state take a balanced and thoughtful approach to resolving these issues with vigorous and widespread input by all affected parties. Any failure of health insurance reform through a hasty or misinformed process of deliberation will have serious negative consequences for the citizens of the state. By taking a deliberative and restrained approach to insurance market reforms, Illinois will give itself the chance to grow and amend the Exchange program over time based on actual experience in the marketplace. IHA looks forward to being part of the process to make sure Illinois establishes a successful Exchange that will benefit Illinois consumers.

B. Medicaid Reform

A key provision of health care reform and a critical priority for Illinois is reforming the Medicaid program to ensure that it is as cost effective and efficient as possible, and results in the best outcomes for our patients. One of the most significant underpinnings of health care reform is the Patient Protection and Affordable Care Act's (ACA) provision calling for a major expansion of Medicaid to cover all people with incomes up to 133 percent of the Federal Poverty Level (about $14,000 for an individual or $30,000 for a family of 4). In Illinois, that means about 700,000 more people will be potentially eligible for Medicaid, an enrollment increase of more than 25 percent. By far, this represents the largest group of currently uninsured Illinoisans who will be able to obtain coverage under health reform.

We all recognize that maintaining the status quo is no longer acceptable. We not only need to transform our health care delivery system, but also address the state's continuing fiscal challenges. When people talk about transforming health care so that every patient gets "the right care in the right place at the right time," and about "bending the cost curve," those phrases sound simple enough on the surface. But they represent a highly complex challenge for all of us. Hospitals, physicians, home health and long-term care providers, insurers, policymakers, government and other key stakeholders – we must all work to sustain and strengthen the Medicaid program and the health care system in the short-term, while developing innovative approaches and reforms to transform Medicaid and health care in the long-term.

IHA and the hospital community are strongly committed to continuing their partnership with the state to support a cost-effective, efficient Medicaid program that promotes timely access to quality health care. Illinois hospitals have consistently collaborated with the State over many years to identify pragmatic and workable mechanisms to control Medicaid costs and improve care – including developing

primary care case management and disease management, reducing inappropriate prescription drug utilization, and promoting medical homes for Medicaid patients.

It is important to keep in mind that the Medicaid program not only ensures the health and well-being of all Illinoisans as a vital part of the state's health care system, it also provides a huge stimulus to the local and state economies. As Medicaid dollars are cycled through the health care system and the economy, they generate revenues and bring in considerable, additional non-state funding – and they support hospitals in their role as major economic engines.

As the Council considers strategies and reforms for the Medicaid program, we urge you to "first, do no harm" to patients and the health care delivery system. We urge you to review what is working well and build on those approaches, and to test out new strategies through pilot and demonstration projects before considering their implementation on a wider scale.

Recommendations Related to Medicaid Reform

The following comments focus on four specific issues related to Medicaid reform:

1) **After January 1, 2014, the Affordable Care Act (ACA) will make about 700,000 more Illinoisans eligible for Medicaid by covering all people with incomes less than 133% of the Federal Poverty Level (now about $14,000 for an individual or $30,000 for a family of 4), with 100% federal funding for the first four years. What are the implications of this significant expansion for the Medicaid program? Within the bounds of the State's fiscal condition, what changes would improve the Medicaid program?**

The expansion of the Illinois Medicaid program – with 100 percent federal funding – provides an excellent opportunity for the state to address critical needs, explore new strategies and models of care, and pilot innovative approaches to deliver care – with the intent of discovering methods that provide better value and outcomes. At the same time, under the ACA, the federal government is providing funding for pilots and demonstration projects. We urge the state to seek federal funding to test new approaches and strategies for the Medicaid program.

The Need for New Care Management Approaches

Over-utilization and avoidable utilization of health care services is as unwise as it is costly. The challenge for the Medicaid program, and any other health care payment system, is to incentivize the delivery of the right care at the right time in the right place. The existing volume-based payment incentives may not always promote such care and new, value-based approaches need to be tested and workable solutions should be adopted.

It should be noted that IHA and the Illinois hospital community have long been engaged in the relentless pursuit to advance quality patient care and outcomes across the state. In 2010, IHA created the Quality Care Institute, a statewide center, to promote excellence in performance improvement across Illinois' delivery systems. The Institute's dynamic efforts build upon existing quality and safety initiatives, engaging our organizations in shared learning networks and applying innovative strategies for strengthening the quality of health care delivery – with the ultimate objective of becoming national

leaders in quality patient care. We are pleased to report that nearly 200 hospitals and health systems are actively engaged in the Institute's "Raising the Bar" campaign to substantially reduce readmissions, and hospital-acquired conditions and infections.

Care management, while not a new or revolutionary idea, is a central theme of health care reform. Its goal is to bring together primary care physicians, specialists, hospitals, long-term care and social service providers to organize care around the needs of the patient to achieve improvements in health more efficiently and effectively. Although the wisdom of care management has never been questioned, our volume-based payment systems have never adequately funded or incentivized this approach which may include payment to providers for the time spent maintaining contact with the patient between visits, as well as with the patient's other providers, in order to coordinate care for patients who may have multiple health issues and see many providers. To make care management a viable solution to inappropriate health care utilization, our payment systems need to incentivize such care. One of the most promising new payment ideas borne out of health reform is the creation of Accountable Care Organizations (ACOs), which are designed precisely to incentivize care management.

Medicaid ACO Demonstration Projects & Grants

IHA recommends that Illinois pursue the analysis and development of a multi-year, federal Medicaid waiver to bring substantial federal resources to the state to fundamentally restructure our Medicaid program toward accountable, value-based care. With these federal funds, the Illinois Medicaid program should support and fund a number of ACO pilots or demonstrations throughout Illinois to determine whether and how this care management approach can significantly improve the care of Medicaid beneficiaries and slow the rate of growth in the cost of covering this population.

To achieve meaningful results, the state will have to use these new federal monies for the up-front investment of resources required to give these pilots a realistic opportunity to succeed. Federal Medicaid waivers and grants offer a tremendous opportunity for Illinois to promote this initiative without having to fund it completely out of state revenue. The following elements would need to be included in this bold and innovative approach.

Start-up Funding:

1. **Investing in Delivery System Infrastructure Improvements.** ACOs must implement meaningful and identifiable reforms in care delivery, patient engagement, and other aspects of health care that will credibly improve health and reduce the growth in costs. The state should provide funding for the creation of an ACO provider network with an ACO management structure for administrative and care coordination support (e.g., claim adjudication; ACO provider network contracts; management of incentive payments to providers; provider relations and coordination; care and utilization management; and quality and efficiency measurement).

2. **Health Information Technology.** The State should fund health information technology for each ACO that connects all of the ACO providers and allows for proactive patient care management and the clinical tracking of patients throughout the delivery system.

ACO Elements of Success: The core elements of a successful Medicaid ACO pilot include the following:

3. **Primary Care Focus.** ACOs must be established on a strong foundation of primary care to promote preventive health care and to enhance patient wellness. Accordingly, the State must offer ACOs sufficient funding to attract primary care providers to serve in these demonstrations for primary care management of the Medicaid population that is enrolled in a participating ACO.

4. **Continuum Care Capacity.** The ACO must be able to manage the full continuum of care for all of its Medicaid beneficiaries, from primary care to end of life service.

5. **Sufficient Size in Patient Populations.** The state must assure enrollment of a sufficient number of Medicaid beneficiaries in each ACO to ensure that their quality and cost impacts can be reliably measured and evaluated.

6. **Data and Healthcare Analytics.** The state should assist the ACO in understanding the health risks of its Medicaid population and appropriately fund the analytical resources they will need to achieve the desired level of care coordination that improves quality and contains costs.

7. **Shared Savings.** Although the existing volume-based payment system may be the default approach for some services, the state should develop new ACO payments that provide incentives to avoid cost and create savings, such as medical home payments, care management fees, bundled payments, and other possibilities. The state should also offer ACOs performance bonuses for achieving measurable quality targets and reductions in overall spending growth for its Medicaid population.

8. **Provider Incentive Payments.** ACOs must offer realistic and achievable opportunities for their providers to share in the savings created from delivering higher-value care.

9. **Performance Measurement.** ACOs must participate in ongoing performance measurement that provides meaningful evidence of health and cost impacts. Results, including patient experience, clinical process and clinical outcomes, must be transparent and accessible to patients and the state.

10. **Time.** It will take each successful Medicaid ACO pilot applicant at least twelve months to establish the infrastructure and operational policies and procedures to implement the ACO-style of care. For the state to get a credible understanding of how well each of its Medicaid ACO pilots performs, it is recommended that each pilot be allowed to operate for at least three years beyond its first year start-up unless the ACO decides to withdraw from the demonstration because of financial or operational hardship.

IHA looks forward to working with the state to pursue the federal waiver and funding opportunity described above. The need to find better ways to treat our Medicaid population coupled with the possibility of doing so with federal financial assistance are compelling reasons for proceeding down this promising path. As we look ahead, we must seek to not only preserve existing federal financial support for Medicaid, but also pursue new opportunities to enhance that support. IHA stands ready to assist and work with the state in this quest.

Integrate Behavioral Health Services with Primary Medical Care

Another innovative approach the state should consider is a **new model of care that integrates and coordinates behavioral health care with primary medical care**. Such an approach would **make behavioral health services available to a wider population** – especially to single adults without children. The state would be able to obtain federal Medicaid matching funds to help pay for those services, which are currently funded with state funds only.

Over the past several years, hospitals in Illinois have been serving a large and steadily increasing number of persons with mental health and substance abuse illnesses – who did not qualify for Medicaid or Medicare – in their emergency departments, inpatient beds and specialty facilities. Individuals with mental illnesses often go to the hospital emergency room in crisis because treatment was not available to them sooner and in a more appropriate setting. This unnecessarily drives up health care costs.

The U.S. Surgeon General, the Institute of Medicine and the President's New Freedom Commission on Mental Health have all concluded that primary medical and specialty psychiatric care should be integrated. They note that mental illnesses are treatable diseases, and in many cases, occur concurrently with medical conditions. For example, one-fifth of persons hospitalized for cardiac conditions have depression. Persons with serious mental illnesses die at a much younger age than the general population because of untreated medical conditions.

The situation has only worsened over the past few years, as Illinois' community mental health and substance abuse systems have sustained major funding cuts, depleting the availability of services in communities across the state. The expansion of the Medicaid program presents an opportunity for the state to **enhance and rebuild community-based services**, thus reducing unnecessary utilization of hospital emergency rooms and inpatient psychiatric services, and costs.

Expand the Use of Telemedicine

There is a severe shortage of psychiatrists in the state, especially in rural Illinois and especially for children. Of the state's 102 counties, 50 do not have a single psychiatrist, and 84 do not have a child psychiatrist. Access to behavioral health services in rural Illinois has always been a challenge because of the lack of psychiatrists and other mental health professionals and the resulting lack of hospital inpatient units. Behavioral health patients in rural areas must travel great distances to obtain care. The limited number of transportation options in rural communities makes it difficult for patients to get to the few treatment options that do exist. As a result, rural hospitals are treating increasing numbers of behavioral health patients in their emergency departments until transportation and appropriate beds are available.

We urge the state to support and fund the **expanded the use of telemedicine for psychiatric services**. Telemedicine has been proven to be an effective tool in bringing the expertise of academic and specialty medicine, including psychiatry, to rural communities in Illinois. For example, some hospitals have begun to use telemedicine for psychiatric patients in partnership with the Southern Illinois University School of Medicine and the University of Illinois at Chicago. Funding is needed to expand the ability of other rural hospitals to obtain psychiatric services. Some hospitals also need assistance in order to obtain the equipment necessary for telemedicine.

Another innovative approach that we urge the state to consider is telemedicine consultations to improve outcomes for high-risk pregnancies in rural areas, which has been proven to be successful in Arkansas. Under the ANGELS (Antenatal & Neonatal Guidelines, Education, and Learning System)

program, that state has developed a clinical telemedicine system to ensure local access to high-risk obstetrical care and pregnancy services, maternal-fetal medicine specialists, and prenatal genetic counselors. The program facilitates real-time telehealth consultation between patients, their local physicians and medical center specialists through a statewide telemedicine network. ANGELS significantly reduced Arkansas' 60-day infant mortality rate in the first two years of the program.

Ensure Adequate Provider Networks

A major challenge for the state in expanding the Medicaid program is ensuring an adequate network of health care providers, including primary care and specialty providers. Coverage is not access to health care if there are not enough providers to meet the new and increased needs of a significantly larger Medicaid population.

Historically, due to the Medicaid program's low reimbursement rates to providers, Medicaid beneficiaries have had great difficulties in finding providers to treat them, especially in rural and underserved areas of the state. Now, the state faces a growing shortage of physicians, especially primary care physicians. (Please see "Workforce" section of this paper.)

Explore Payment Reforms to Improve Quality and Outcomes

We applaud the Department of Healthcare and Family Services for its efforts to transform itself from an agency that "simply pays bills for services after [its] clients get sick – to being a proactive agency that focuses on helping to keep people healthy." We note that the Department already offers **bonus payments to primary care providers for high performance** in *Illinois Health Connect* medical homes. In the 2010 General Assembly session, IHA supported legislation (SB3743/PA96-1130) that enhances payments to long-term acute care hospitals that choose to participate and meet certain quality standards.

The hospital community looks forward to continue working with the Department to consider and **test incentives for cost-effective, quality care, based on outcomes**. In the years to come, the Medicaid program expansion provides an opportunity to explore various payment reforms that could lead to more cost effectiveness and efficiencies, quality improvement and better outcomes. Such reforms might include the **bundling of payments** for an "episode of care" to various providers in different settings, such as the physician's office, the hospital and the nursing home, in an effort to increase patient care coordination among providers.

2) **These low-income individuals and families will likely move, from one year to the next, between public coverage through Medicaid and private health insurance supported with tax subsidies through the Health Insurance Exchange. How should we ensure continuity of care – in benefit coverage and in provider networks?**

To ensure continuity of care among those who may move between Medicaid and private insurance provided through the Health Insurance Exchange, it will be critical for the state to **establish consistent coverage standards and policies and reasonable provider rates for Medicaid**. Benefit packages should be comprehensive and similar, under Medicaid and private insurance provided through the Exchange. If a patient needs health services, whether through Medicaid or an Exchange health plan, he/she should have similar coverage, and similar access to providers. To achieve this goal, the Medicaid provider rates

will need to be comparable to the provider rates negotiated by the private plans offered on the Exchange.

As a cautionary note, given the importance of having an adequate network of providers, the state should be careful not to use Medicaid reimbursement rates, which are already low, as the floor for the rates in the Exchange. Inadequate rates would only discourage physicians from participating and result in challenges for Medicaid beneficiaries in finding primary care physicians, and even more difficulties, in finding specialists who will care for them.

We urge the state to **establish a committee of key stakeholders**, including hospitals and other providers, to **review proposed coverage standards and policies** for the Health Insurance Exchange.

3) **The ACA focuses on care management as a central theme of health care reform, with the goal of bringing together primary care physicians, specialists, hospitals, long-term care and social service providers to organize care around the needs of the patient to achieve improvements in health. How should the state incorporate the integration of medical services into the Medicaid program?**

As noted above under issue #1, we urge the state to explore and implement Medicaid ACO Demonstration Projects.

However, it is also important to note that the state has already taken some important steps in moving to integrate medical services into the Medicaid program. We commend the state and the Department of Healthcare and Family Services for establishing the Primary Care Case Management (PCCM) and Disease Management (DM) programs. The programs have shown great promise and substantial savings in their first few years of operation.

The PCCM and DM programs keep people healthier and help keep costs in check by preventing inappropriate and costly emergency room visits and hospitalizations. Each client is assigned a "medical home" where they receive regular ongoing care and have access to primary care doctors who provide regular checkups and preventative care. Through extensive outreach efforts, Illinois Health Connect has more than 5,000 "medical homes," including physicians and Federal Qualified and Rural Health Centers across the state.

The disease management program provides an even more intensive and comprehensive approach to patients with chronic disease, such as coronary artery disease, asthma or depression. The program coordination includes the use of nurses and social workers to ensure that participants obtain the help they need for their health, food and housing issues to get better control of their situations and reduce the incidence of costly medical crises.

These programs are all about managing and coordinating care, making sure that people get the right care at the right time in the right place, so that they are not unnecessarily using the hospital emergency room and driving up costs. Through good PCCM and DM programs, the state is accomplishing those goals. The state should not abandon the PCCM or DM approaches.

Enhance Primary Care Case Management and Disease Management programs.

We urge the state to **expand and refine the PCCM and DM programs to include additional populations, conditions, and providers.** For example, the PCCM program could be enhanced to include long-term care services as part of the "medical home." It could also be expanded to include clinics, Federally Qualified Health Centers, physician groups, and Accountable Care Organizations. Through an enhanced PCCM program, the state should be able to achieve better integration of services, not just by individual physicians, but also by physician groups, clinics and hospitals, who should be included as strategic partners in this effort.

Several other states, including Arkansas, Indiana, North Carolina, Oklahoma, and Pennsylvania, have sought to enhance their basic PCCM programs with additional features. While each state uses different resources for care coordination and care management and uses different care coordination methods, common themes in their approaches include: more intensive care management and care coordination for high-need beneficiaries; improved primary care physician incentives; information sharing; and increased use of performance and quality measures. We urge the state to look at those approaches as well as other enhancements to the PCCM program, including:

- Tie per member per month payments to specific outcomes that require the physician to actively engage and provide appropriate primary care to the Medicaid beneficiary;
- Disciplines, incorporating provider risk-sharing such as reductions in per member per month payments, should be considered to encourage physicians to provide top care, including adequate hours and access to care;
- Focus on true incentives for the provider and patient to reward healthy lifestyles and ensure that primary care physicians are making only proper referrals; and
- Limit doctor shopping within the PCCM system to allow for proper care management.

We also recommend several changes in the DM program, which is currently voluntary for enrollees with chronic conditions, including:

- Participation in the existing disease management program by **all beneficiaries** who are in the high-cost category or at risk of joining the high-cost category should be pursued;
- Payment for service should be contingent on meeting performance metrics and improving health outcomes; and
- Mechanisms to tie payments to the program's vendor to savings and health outcomes should also be explored.

Explore Care Coordination Approaches Through Demos and Grants Under ACA

Care coordination – focusing not just on primary care, but the entire spectrum of a patient's health care needs – can reduce hospitalizations, lower the rate of complications from chronic conditions, and help eliminate health disparities. Structured appropriately, care coordination can improve outcomes and reduce costs. The Affordable Care Act includes a number of new demonstrations and grants focused on service delivery and payment reform. The hospital community welcomes the opportunity to work with the state and the Department of Healthcare and Family Services to assess the feasibility of various options available under the ACA, including:

- Medicaid Integrated Care Hospitalization Demonstration Program: Up to eight states will be selected to use bundled payments to promote integration of care around hospitalization;
- Medicaid Global Payment System Demonstration: Up to five states will be selected to test paying a safety net hospital system or network using a global capitated payment model;
- Pediatric Accountable Care Organization Demonstration Project: Will allow pediatric providers to organize as accountable care organizations (ACOs) and share in federal and state Medicaid cost savings;
- Medicaid Emergency Psychiatric Demonstration Project: Will provide Medicaid payments to institutions for mental diseases (IMDs) for adult enrollees requiring stabilization of an emergency condition;
- Medicaid Chronic Disease Incentive Payment Program: Will provide states grants to test approaches that encourage behavior modification for healthy lifestyles; and
- A new program to develop and advance quality measures for adults in Medicaid. A similar initiative for children was included in the Children's Health Insurance Program Reauthorization Act (CHIPRA).

As the state explores approaches to improve coordination of care across the spectrum of providers, we urge the state to include hospitals and other stakeholders to develop the best approaches and avoid unintended consequences that could undermine the health care system. When considering new ideas, we urge the state to test, to "prove the concept," through pilots and demonstrations. Many of our hospital members are ready and willing to participate in pilots and demos as they are seeking ways to improve the coordination and integration of care for their patients.

4) **The ACA emphasizes home and community-based services to reduce the reliance on institutionalization for seniors and persons with special needs and offers new state-plan options for states to cover these services. What changes should be made in Illinois' long-term care services system (both institutional and community based) to improve the quality of care and achieve the most cost-effective delivery of appropriate care to achieve the best outcomes for these complex cases?**

Rebalance long-term care services

The state should rebalance and reduce its reliance on institutional care in the Medicaid long-term care system. Individuals who are aged or living with a disability or serious mental illness should remain in the communities in which they live, with quality services provided to them on a medically practical and cost-effective basis. Specific strategies to achieve this goal might include:

- Enhancing the Community Care Program for Medicaid-eligible seniors;
- Enhancing community options for people with developmental disabilities who are living in state or privately-run institutions;
- Enhancing and expanding community-based programs for those with mental illnesses; and
- Managing admissions to ensure a short institutionalization period and facilitate rapid reintegration to a community setting.

Maximize Federal Funding for Medicaid in the Short-Term and Long-Term

While we were not asked to specifically address the issue of funding, it is important to consider the issue of resources to sustain and support the Medicaid program in the short-term and in the long-term. We urge the state and its various agencies, including the Departments of Healthcare and Family Services, Human Services, and Aging, to continue their efforts to **increase and maximize their claims for federal Medicaid reimbursement for as many qualifying services as possible**, now through the end of June, 2011, under the state's enhanced federal matching rate (FMAP).

To ensure that the state can adequately support the Medicaid program (and reduce its need for state funds), we strongly urge the Governor, General Assembly and Illinois Congressional Delegation to push for a **permanent increase in the state's federal Medicaid matching rate**. When the state's enhanced rate expires next June, Illinois will return to the lowest federal matching rate, even though it provides disproportionately more Medicaid services than many other states.

Finally, we urge the state to **explore other ways to obtain federal funding for the Medicaid program,** including considering innovative approaches similar to California's recent success in securing $10 billion in federal Medicaid support over the next five years through a Medicaid waiver. We welcome the opportunity to work with the state on such a bold approach while federal funding is still available. Given Illinois' geographic and demographic diversity, the state would be an excellent testing ground for the Midwest and the nation for Medicaid innovations and warrant federal funding support.

Conclusion

IHA and the hospital community are strongly committed to their partnership with the state to not only preserve and protect the health care delivery system in the short term to ensure its sustainability, but also to transform the health care system in the long term. We look forward to continue working with the state for a cost-effective, efficient and quality Medicaid program that focuses on good outcomes for patients and collaborating on ways to develop and maintain reliable, sustainable and predictable funding sources for Medicaid and the health care system.

C. Incentivizing Delivery System Reforms to Improve Quality and The Use of Health Information Technology

A key priority of health care reform is to improve the quality of health care and a robust health information exchange plays a critical role in achieving the best outcomes for our patients and communities.

The Patient Protection and Affordable Care Act's (ACA) provisions addressing quality are intended to transform health care so that every patient gets the right care, at the right time, in the right setting, with the right positive patient outcome. In IHA's relentless pursuit to advance quality patient care across Illinois, IHA has created the Quality Care Institute, a statewide center, as a visible commitment to promote excellence in performance improvement across Illinois' delivery systems. The Institute's dynamic efforts build upon existing quality and safety initiatives, engaging our organizations in shared learning networks and applying innovative strategies for strengthening the quality of health care

delivery – with the ultimate objective of becoming national leaders in quality patient care. Campaigns for reducing hospital readmissions, and hospital-acquired conditions and infections are well underway.

Recommendations Related To Incentivizing Delivery System Reforms

The ACA seeks to increase the value of health care expenditures by raising the bar on quality and, at the same time, exert downward pressure on the cost curve. Such changes are predicated on a movement away from payment based on the volume of care provided. IHA supports changes needed to increase quality and control costs. However, the perfect replacement for a volume-based payment system is not yet evident. Indeed, it may take different forms, depending on individual providers and locations. Therefore, the Act offers many opportunities for piloting innovative approaches to delivering health care, with the intent of discovering methods that provide better value. One of the approaches is the "medical home" where each patient receives primary care and management of overall care to address chronic conditions and promote wellness. Another involves bundling the payment for an "episode of care" to various providers in different settings, such as the physician's office, the hospital, and the nursing home, in an effort to increase patient care coordination among providers.

Another health reform model that is being promoted is the Accountable Care Organization (ACO) which enables groups of health care providers to become jointly responsible for a population of assigned Medicare patients, and to share in savings realized from higher quality and lower cost patient care. IHA supports the ACO concept as a key framework upon which to build collaboration and efficiencies and will work with its members, the state and other interested parties to implement ACOs.

Efforts are already underway. Advocate Health Care, the state's largest health care system and a national model for clinical integration has recently announced that it and Blue Cross and Blue Shield of Illinois have entered into a shared savings type agreement that holds the ten Advocate hospitals and physicians accountable for reaching performance targets tied to improved quality of care to patients with coverage under the Illinois Blue Cross HMO and PPOs. In exchange for improving quality, safety and efficiencies, Advocate has the opportunity to share in the savings generated by more coordinated care that also weeds out waste from the system.

Key Issues to Consider in Incentivizing Delivery System Reforms

Identifying better ways to accomplish a goal always takes much time and effort, and it is no different for health care reform. So what is needed during this time of discovery? In implementing federal health care reform, we urge the State to consider the following principles:

- **Reinvest Savings in Health Care.** As the state implements health care reform and achieves savings in existing state health care programs, such as Medicaid, those savings should be reinvested in further improving access to quality health care, especially for the substantial number of persons who will not be covered by the expansion of Medicaid.

- **Flexibility.** Because hospitals are key economic engines for Illinois communities, generating not only hundreds of thousands of jobs but also billions of dollars for the state's economy, it is critical during this transition, that hospitals have flexibility to sustain current operations, while simultaneously taking steps to re-align, integrate with other providers, and better coordinate

care, in accordance with an expected plethora of new federal rules. The State must resist establishing rigid requirements that impair these efforts.

In addition, the State should provide for periodic evaluations of new arrangements and requirements, to allow for mid-course corrections that reflect what is learned by early adopters of new delivery and payment systems.

- **Ability to Form or Join Systems of Care.** State regulations should allow for new business arrangements among health care providers, and new payment mechanisms. This may require amendment of current rules governing the relationships among providers to incentivize collaboration and the distribution of shared savings. For example, new exceptions to the health care worker prohibition on self-referral may be necessary to accommodate the distribution to providers of shared savings achieved by more efficient and cost-effective care. The State should consider adjustments to statutes and regulations that may be needed to create a pathway for all types of providers to collaborate by forming or joining new accountable systems of care.

  One area where the state should focus immediate attention is promoting behavioral health systems of care that integrate mental health and medical care. We hear from all across the state that the behavioral health system in Illinois is broken. There are sparse resources for patients who could be cared for in community based settings. So when patients are in crisis, they seek care in hospital emergency departments. Particularly in rural areas, hospitals do not have the resources to provide the best care for these patients. There are few psychiatrists and other mental health professionals.

  To maximize the use of very scarce resources and improve care for behavioral health patients the state should facilitate the formation of regional behavioral health systems of care. These could include Federally Qualified Health Centers (FQHCs) and telemedicine networks, among other elements.

- **Ability to Enter Into Arrangements with Insurers**. The State should encourage arrangements between health care providers and insurers as part of the quest for a system that rewards higher quality, more efficient care and incentivizes hospitals and physicians for the care management role that currently is uncompensated.

- **Consistency among Federal, State and Private Payors.** As the state seeks to implement health care reform, it is important that incentives and approaches adopted by the state be consistent with approaches adopted by the federal government and private payors. Hospitals have struggled in recent years with having to comply with and respond to quality improvement initiatives and reporting requirements imposed by different levels of government. Adopting standardized measurements approved by the National Quality Forum and Centers for Medicare and Medicaid Services will support focused quality improvement efforts and reduce administrative burdens by having to report processes and outcome measurements using publicly adopted standards.

- **Streamline Current Rules.** State regulators of hospitals should work with IHA to identify opportunities to streamline current rules governing hospital operations, in preparation for the state's promulgation of additional rules to implement federal health reform.

- **Reasonable Expectations.** While coordinated systems of care can be expected to promote both higher quality care and reduce the rate of growth in health care expenditures, cost savings may not be immediate. Hospitals will need time to align with physicians and other providers across the continuum, continually analyze data to assess their performance, and continually implement improvement strategies. This will not happen overnight.

Health Information Technology

There is considerable and growing evidence of the value to patients and the cost savings resulting from the implementation of electronic health records (EHRs) and health information exchanges (HIEs). Hospitals implementing EHRs achieve greater effectiveness and efficiencies with increased technology support through usage of evidence based practices; reduction of administrative burdens; increased coordination of care; decreases in redundant laboratory and diagnostic exams; usage of drug interaction tools; development of continuum-of-care plans for patients; improved processes and outcomes of care due to interactive intervention reminders; and increased care coordination for patients among multiple specialists and care givers.

High performance HIEs and EHRs are critical to provider efforts to implement new and better health care delivery system models to improve the quality of care for all patients, advance public health, and reduce costs. Access to objective health care information is essential to better understand processes and outcomes of care and to improve coordination of care along a continuum. It is also important that the information on patients be protected and kept secure but be available when patients need it. Building the Health Information Technology (HIT) highway to the future, however, is a complex challenge mandating involvement and collaboration from numerous stakeholders and multiple funding sources. The state's continuous and enhanced involvement is essential.

Currently there are several initiatives throughout Illinois aimed at developing local and regional HIEs. These preliminary efforts require state support and encouragement with the understanding that in time they will need to easily connect to maximize information exchange and operational efficiencies. The state must rapidly increase its involvement and commitment to advance HIE and to obtain federal funding so Illinois is positioned to implement and operate a statewide HIE. With the majority of health care providers required to be EHR and HIE compliant by 2017 or face financial penalties, we need the state to provide the HIE infrastructure in which local, regional and state HIEs can operate.

IHA and Hospital Community Engaged in HIE Implementation Planning

Under the Illinois Office of Health Information Technology (OHIT), the HIE Advisory Group has developed strategic directions and relationships with partners from health care sectors throughout the state. The Advisory Group has formed multiple work groups composed of health care stakeholders, including hospitals, to address issues including:

- Behavioral Health
- Clinical Quality and Integration
- Consumer/Patient Education and Public Awareness
- Finance Sustainability
- Governance
- Medicaid

- Privacy and Security
- Public Health
- Technology/Interoperability
- Telehealth

IHA is actively engaged with OHIT, with representation on the HIE Advisory Group and several of the work groups, providing recommendations to help OHIT develop an effective HIE implementation plan for the state. IHA recently hosted a call with OHIT for our hospital and health system members to encourage them to complete OHIT's survey of providers to gauge their readiness in implementing "meaningful use" EHRs and HIE. The survey results will identify any gaps among providers in planning and implementation.

Several key steps need to be taken by the state in the coming months to make sure that Illinois has the structure and funding in place to implement HIE.

Recommendations Related to HIE/HIT

State Should Submit its Medicaid Incentive Plan in January 2011

Under the ACA, hospitals and physicians that provide care for Medicaid patients are eligible to receive incentive payments for EHR implementation that meets "meaningful use" criteria. The HIE Advisory Group and the Medicaid Work Group have been working closely with OHIT and the Illinois Department of Healthcare and Family Services (HFS) to develop the meaningful use performance-based incentive plan so HFS can apply for federal matching dollars. The goal is for the state to submit the plan for the first phase in January 2011 so EHR funding for eligible physicians and hospitals is available in the spring. **We ask for the state's continued support in ensuring the HFS plan for Medicaid EHR incentives is submitted in January 2011 so hospitals and physicians can build and enhance their EHRs.**

Illinois HIE Authority Should be Appointed as Soon as Possible

In order to develop and implement a sustainable HIE plan, we respectfully urge Governor Quinn to move expeditiously to appoint the eight directors and executive director of the Illinois Health Information Exchange Authority. Under legislation (HB 6441/PA96-1331) passed overwhelmingly by the Illinois House and Senate and signed by Governor Quinn in July 2010, the HIE Authority will establish and operate the HIE and foster the widespread adoption of electronic health records and participation in the HIE. As the General Assembly identified the Authority as a key component in advancing HIE within Illinois, **we ask that the Authority's directors and executive director be appointed as soon as possible so that HIE plans can advance in Illinois and eligible providers can receive their incentive payments in a timely manner.**

Development of HIE Plans

The U.S. Centers for Medicare and Medicaid Services has a matching program for HIE information infrastructure developments through state Medicaid plans. **We ask that the state develop its Medicaid HIE infrastructure plan and utilize Medicaid Management Information Systems funds to implement information infrastructures for EHR and HIE implementation.**

Because the state and various stakeholders are committing substantial resources and time in developing and implementing *regional* HIE plans, **we ask that any plans developed by the HIE Authority and any plans needing federal approval require participation in a regional HIE, health system, or the state HIE**. Most health care is local, as are referral patterns as identified through the local Medical Trading Areas (MTAs) and their HIE plans developed over the past 18 months. If a provider opts to utilize HIE services outside its MTA, it should be through the state HIE. **Local MTA, health system, and state HIE initiatives need to be financially sustainable, so participation in one or more of them should be required.**

We also request that any information required by the Illinois Department of Public Health (IDPH) be allowed to be submitted through health care provider EHR or HIT systems as long as the reported data and information meets the standardized format and content specifications provided by IDPH.

Continuation of Healthcare Stakeholder Engagement

In addition to the Illinois HIE Authority, it will be critical to continue the engagement of health care stakeholders in discussions and development for EHRs and HIE. The OHIT has played a critical role in facilitating discussions among current and potential future trading partners, in advancing the implementation of EHRs among hospital and physicians, and providing a forum for HIE discussions among Medical Trading Area grant recipients. **We ask that the state continue the support for OHIT and its initiatives and that the ongoing collaboration continue between OHIT and various health care stakeholders.**

Advance Illinois Quality of Care and EHR Concerns to the National Level

While IHA has raised these issues at a national level, **we ask that the state join IHA and request that federal funds be available for hospital systems that operate multiple hospitals under a single payer identification number and that behavioral health, rehabilitation, and long-term acute care hospitals be afforded the same incentive plans to implement EHRs and HIE.**

Currently, there are several system hospitals within Illinois that operate under a single hospital identifier for their system and are not eligible to participate in the incentive plan for each of their hospitals. Additionally, several types of hospitals that play a critical role in health care delivery are systematically excluded from participating in incentive plans. The behavioral health, rehabilitation, and long-term acute care hospitals serve many patients throughout Illinois and often times receive and transfer patients to acute care hospitals. With these hospitals not having EHR incentive plans to participate in EHRs or HIE, the value of EHRs and HIE for acute care hospitals is diminished when receiving patients from or transferring patients to these hospitals.

Conclusion

Our Illinois hospitals' first priority is to provide safe, quality care to our patients. IHA is ready and willing to continue our work with the state and other interests to address health care reform efforts that best

complement and advance that objective. IHA appreciates the opportunity to express our concerns and recommendations and looks forward to putting Illinois on the map as a premier state for health care quality and patient safety.

D. Health Care Reform and Workforce Development and Retention

Health care reform offers a great opportunity to improve the lives of our communities by working together to transform our state's health care delivery system from one that is frequently uncoordinated and fragmented to a true system of care – one that is coordinated, collaborative and accountable. Key to that effort is developing and sustaining an adequate number of qualified health care professionals to provide a range of health care services across the state.

However, like hospitals across the nation, Illinois hospitals' ability to render their services are threatened as they continue to face both an immediate need for qualified physicians and staff and a long-term shortage of health care workers in many health care job categories. An aging baby boomer population, inadequate educational capacity, financial constraints, and other stresses have contributed to both an increased demand for health care services and corresponding occupational shortages.

The ongoing challenges of attracting and retaining replacements for both retiring practitioners and academic faculty, and meeting the growing need for more health care services, has been an area of acute need and some collaborative activity in recent years. Yet, the promise of health care reform imposes additional and unprecedented demand requiring new ways of thinking, collaborative efforts and action from our state government. **Most importantly, the state needs to develop and intentionally realign its infrastructure to meet the increasing demand for our health care manpower.** Our hospitals sincerely appreciate the Illinois Health Care Reform Implementation Council's efforts to encourage the involvement of interested stakeholders and the public in your statewide forums to address workforce development and retention.

Recommendations Related to Workforce Development and Retention

State Support Necessary to Implement Innovative and Redesigned Delivery Models

Expanding Illinois health care workforce is a complex challenge requiring initiatives and solutions that address numerous points on the supply continuum, including career awareness, student preparation, educational capacity, licensure, and recruitment and retention. Illinois needs to support strategies and resources that coordinate federal, state and local workforce development efforts, and to connect workforce education with the delivery of health care services. The Patient Protection and Affordable Care Act provisions for coverage expansion to 1.9 million Illinoisans will compound demands on an already inadequate health care workforce. The Act's emphasis on primary care providers to improve patient access and quality outcomes will exacerbate the increased need for physicians and mid-level providers, such as advanced practice nurses and physician assistants. Furthermore, current shortage projections for these providers and other practitioners fail to account that there must be changes in the way care is organized, delivered and financed. Redesigning work processes and incorporating new technologies to improve patient outcomes, and increase efficiencies and employee satisfaction have to be supported by updated state processes and oversight. **Exploring approaches and eliminating barriers**

to allow for the expanded use of advanced practice nurses and physician assistants to meet the heightened demand for services offers an important example of how our state's infrastructure must change to complement new health care delivery models and available manpower resources.

The state must evaluate the laws and regulations on licensure, scope of practice and payment to anticipate and expect that our citizen's health care will no longer benefit from individual professions protecting their turf. Instead there must be a rapid paradigm shift to integrate education and practice so that Illinois' "new normal" emphasizes demonstrated initial and continuing professional competence, facilitates overlapping scopes of practice, and allows all professionals to provide services to the full extent of their knowledge, training, experience and skills. The state has to play a key role in eliminating any barriers to health care workforce development and deployment.

State Involvement Needed To Address Physician Supply and Retention

Illinois' physician workforce is critical to the delivery of health care to our citizens. Recruitment challenges experienced by our hospitals across the state and increasing wait times for patient appointments raise serious concerns about an increasing shortfall of physicians. It takes at least 11 years from the time a high school graduate begins preparing for medical school to be fully qualified as a practicing physician. The actual training period varies for each specialty. Illinois hospitals are investing in physician training at a cost greater than the funding that Medicare provides. Yet, national data indicates that Illinois is one of six states regarded as a net exporter of new physicians (American Association of Medical Colleges).

In addition, Illinois-specific information about our state's physician workforce, and other health care professionals, is minimal and fragmented. Ongoing, objective data collection and information to assist policy makers, health care organizations, professional and educational organizations, and the public is essential. These stakeholders need data so they can analyze trends in supply, demand, distribution and use of health care workers. Without accurate information, efforts to identify and align effective strategies for enhancing Illinois' workforce resources to meet our patient care needs is left to a costly and inefficient "hit or miss" approach. **While the state has expended efforts for nursing data through the Illinois Center for Nursing, located within the Department of Financial and Professional Regulation (IDFPR), there is an urgent need to expand that initiative and at the very least, add physician workforce data with the intention to progressively include all the major health care occupations, e.g. physician assistants, pharmacists, physical therapists, etc.**

The following highlights some of what is known about the physician workforce:

- According to national estimates, 36% of active physicians are over 55 and most will retire by 2020. Illinois-specific data on physician retirement is unknown;
- Shortage projections for 2020 range from 55,000 (Department of Health and Human Services) to 85,000 (Council on Graduate Medical Education) to 200,000 quoted in *Health Affairs* (assumes national universal health coverage plan);
- Many reports indicate that many of today's younger physicians, both male and female, are choosing to work fewer hours than their older colleagues, thereby increasing the actual physician replacement need;
- In 2006, the American Association of Medical Colleges (AAMC) recommended a 30% increase in the number of medical school graduates, and as of 2008, enrollment had increased by 21%. However, GME-funded residency positions remain at 1996 levels capped by the Balanced Budget Act of 1997;

- 2010 reform legislation did not change the government-funded number of GME positions;
- While Illinois exceeds the national average of medical residents per population, our state faces a significant mal-distribution issue, with southern Illinois having less than half the national average in residency training slots;
- A 2010 Physician Workforce Study, funded by Northwestern University's Feinberg School of Medicine, IHA and the Illinois State Medical Society, found that half of graduating Illinois physician residents and fellows are leaving the state to practice elsewhere. The primary reasons for newly trained physicians to leave Illinois following residency training include the desire to return to their home state and be near family and friends, the medical malpractice liability environment, and the desire to locate in an area with lower costs of practicing medicine.

IHA urges the state to align its infrastructure and adopt policies that will assure patient access to physician and primary care services across Illinois; distinguish Illinois as a physician-friendly state to learn and practice medicine; and promote use of mid-level providers and technology to bridge health care service gaps. To that end, **we encourage consideration of the following recommendations:**

- Develop an ongoing Illinois physician profile aggregating information from multiple state agency databases (IDFPR, Illinois Department of Employment Security, HFS, etc.) that includes demographic data such as:
    - practice retention rate for physicians who completed final course of graduate medical education in Illinois;
    - general or specialty practice;
    - regional distribution;
    - percentage of practice dedicated to direct patient care activities;
    - gender; and
    - retirement projections;
- Support admission and completion requirements for medical education that incorporate incentives to encourage retention of qualified physician graduates for practice in Illinois;
- Support pilots and efforts to recruit and retain medical students, physicians and mid-level providers who will practice in rural, underserved and shortage areas;
- Offer incentives to providers for physician workforce development and integrated training with other health care disciplines, especially mid-level providers; and
- Help position Illinois as a physician-friendly state by supporting initiatives that create a fair medical malpractice environment.

State Must Assist Efforts to Coordinate Workforce Development and Deployment

Illinois hospitals are local employers that provide essential health services to their communities. As an industry, IHA members rely on a highly educated and skilled workforce, employing many professionals with advanced postsecondary degrees. Hospitals across Illinois are engaged in a variety of efforts to create an excellent workplace environment and provide rewarding career opportunities for their employees. Currently, Illinois hospitals directly employ 255,890 people, with each job supporting an additional 1.1 jobs in other businesses and industries. Every dollar that hospitals spend on goods, services and payroll, generates an additional $1.40 in spending throughout the state and results in a total annual impact of $75.1 billion on the state's economy. Health care and social assistance are projected to create the greatest number of jobs of any sector in Illinois – nearly 150,000 jobs by 2018,

and the vast economic activity generated by the health care sector makes it the sixth highest contributor to the state's Gross Domestic Product, accounting for 6.8% of Illinois' economic activity.

Hospitals are concerned about the lack of coordination among area educational institutions, economic development agencies, and employers to align area educational resources with employer opportunities. Not coordinating workforce needs with educational curricula within a community has often led to either an undersupply of qualified candidates for local employers or an overproduction of graduates in areas the economy cannot support. In addition, today's junior high and high school students by and large have limited skills in math, science, and critical thinking, and are not prepared for health care studies leading to entry level professional positions. Hospitals' inability to recruit and employ area residents due to insufficient student preparation may negatively impact the local economy.

In the absence of qualified candidates, Illinois hospitals have had to expend more resources – both time and money – offering remediation support and/or recruiting from outside their respective communities. While every Illinois hospital is impacted by shortages, the problem is most acute in our downstate and rural communities.

This is of great concern to hospitals who must hire qualified and skilled individuals with advanced degrees as the majority of Illinois' licensed health care occupations require an education at or beyond a baccalaureate degree. If large segments of Illinois' working-age population do not pursue and complete postsecondary studies, hospitals are likely to face even larger shortages of qualified health care professionals. Hospitals may need to import qualified workers from out-of-state or compete with other industries for a limited pool of educated "homegrown" candidates. Not having an adequate number of qualified health care workers with advanced degrees potentially limits a hospital's ability to provide quality health care services to its community.

Furthermore, the state must be cognizant of proposed and existing laws impacting workforce supply, education and practice. The Illinois Center for Nursing is a positive example. It was created by statute in 2007 to bring nurse leaders from academia and health care service together to address our state's nursing shortage. Significant progress has resulted from their efforts, including a 25% increase in educational capacity for students pursuing a nursing career. However, other laws and rules unduly challenge health care workforce development. For example, over the past decade nurse-to-patient ratio legislation has been introduced and defeated by the Illinois General Assembly. Mandated ratios presume evidence-based support for the prescriptive proposal, when actually none exists. Static staffing strategies also ignore the reality that it is an interdisciplinary team of health care professionals working together delivering quality patient care and meeting the dynamic nature of patient needs 24 hours a day, 7 days a week, 365 days a year.

As an alternative to static ratios, IHA, in collaboration with the Illinois Nurses Association, has worked over the years with the General Assembly to support the enactment of several landmark pieces of legislation designed to enhance nurses' work environment, increase the nurse supply, and promote patient safety. As a result, our hospitals use staffing strategies centered on patient acuity and nurses' ongoing input, provide public access to reports about nurse staffing correlated to patient outcomes, and evaluate staffing patterns related to reportable adverse events. These efforts support professional nursing and the public's interest and complement the dynamic and complex nature of health care delivery. While the legislation represents steps in the right direction, health care reform demands more from all of us.

The new federal law underscores that current spending on health care is not sustainable and requires that inefficiencies and waste are removed from our delivery systems. It is more imperative than ever before to ensure that any legislative and regulatory actions proceed with a deliberate rationale to allow for workforce and educational initiatives that best promote positive patient outcomes and a healthy public. Health care reform expands today's health care team approach to one of enhanced coordination and integration across the care continuum – and by necessity, imposes the same for our educational partners. Our state must recognize that current oversight processes for professional practice, organizational operations and corresponding educational programs have to change to support rapidly evolving new models of care and an ability to integrate evolving science and technology. **This means there must be interagency awareness and alignment so that any government agency involved in an aspect of regulating health care licensing, education, facilities, reimbursement, insurance, etc. is functioning less as independent silos and more with a systemic regard to favorably impact Illinois' ability to provide needed health care services.**

Conclusion

Illinois hospitals, as key local employers and providers of essential patient care services, have a vested interest in the health of our state's current and future workforce.

Looking Forward

IHA and the hospital community are strongly committed to their partnership with the state to both sustain the health care delivery system in the short term and to transform it in the long term. During the transition, the state must take a balanced and thoughtful approach to implementing health care reform, with vigorous and widespread input by all affected parties. We look forward to putting Illinois on the map as a premier state for health care quality and patient safety as well as working with the state to create sound public policy facilitating tomorrow's supply of qualified and participating health care professionals.

Hospitals are well-positioned to partner with the state to build on current mutual strengths as we move forward with reform. IHA is committed to supporting the state's compliance with the ACA and efforts for a successful transition to what can be a revolutionary system of health care delivery, payment, and patient experience in this state.

For further information, contact Howard Peters at 217/541-1150 or hpeters@ihastaff.org.

Letter to Chairman Gelder

December 3, 2010

Michael Gelder
Chairman
Illinois Health Care Reform Implementation Council

100 W. Randolph, Suite 16-100
Chicago, IL 60601

RE: The Affordable Care Act: Key Issues for Public Comment

Dear Chairman Gelder:

On behalf of our 200 member hospitals and health systems across the state of Illinois, the Illinois Hospital Association (IHA) appreciates the opportunity to respond to the Illinois Health Care Reform Implementation Council (Council) request for comment on Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois as provided by the *Patient Protection and Affordable Care Act* (ACA).

IHA supports the creation of health insurance exchanges (Exchanges) as marketplaces to not only expand consumers' access to health insurance coverage, but also allow consumers the opportunity to choose health plans that fit their needs. With the proper framework and guidance, the Exchanges will ensure the efficient operation of a marketplace for private health insurance. IHA will be addressing all aspects of the ACA that affect Illinois hospitals, including the formation of an Exchange, in a formal document to be delivered to the Council in the near future. We did, however, want to take this opportunity to specifically address the questions presented in the request for comment issued November 16, 2010.

I. Functions of a Health Benefit Exchange

Questions to Consider:
1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

IHA believes that it is incumbent on the state to both elect to establish an Exchange and to ensure appropriate steps have been taken to ensure the Exchange will be operational by January 1, 2014. Allowing the establishment of an Exchange to default to the federal government would not be in the interest of Illinois citizens. Such action would make it difficult for the Exchange to recognize the nuances of state-specific markets, reduce the likelihood of meaningful stakeholder involvement in Exchange decisions, and lead to possible conflicts with existing state programs and regulations relating to the regulation of insurance plans and the administration of the state's Medicaid program.

2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

Key to a successful Exchange is consumer participation and avoidance of adverse selection. Thus, ease of enrollment for consumers, ease of insurer administration, and clarity of oversight of plans are necessary for the establishment of a successful Exchange.

3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

In developing a workable, flexible system of health care coverage through an Exchange, IHA recommends that the state start small by focusing first on the mechanics of providing an efficient private health insurance marketplace for consumers.

4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Given the state's limited assets, IHA believes that the Exchange should allow the market and a plan's self-assessment to determine whether a plan participates in the Exchange. While it might be possible to establish an Exchange that could perform all of the required and optional functions that would be necessary for the Exchange to act as a purchaser of services, such as the Massachusetts and California models, given the lack of familiarity with acting as a purchaser of insurance, the Exchange should limit its role in this respect.

II. Structure and Governance

Questions to Consider:
1. If Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

While IHA has not dismissed the idea of housing the Exchange in an existing department and would actively work to ensure its efficient operation within a departmental structure, IHA supports the establishment of an Exchange as an autonomous state agency with a specifically defined board representing key stakeholders and a director with a set term of service. Not only would such governance maintain stability and neutrality during political change, it would also allow other key agencies, such as the Department of Healthcare & Family Services (DHFS), the Department of Insurance (DOI), and the Department of Public Health (DPH), to continue to focus on their existing duties and responsibilities.

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

IHA recommends that the governing board of the Exchange should be broadly defined with a sufficient number of board members to encompass a diverse variety of stakeholders including health care advocates and providers. Within such a construct, the directors of affected state agencies should serve as ex officio members on the board. Conceptually the Exchange could function in a similar manner to the Illinois Comprehensive Health Insurance Plan (ICHIP), but the director and board would need to be more independent of stakeholder interests than the current CHIP board.

III. The External Market and Addressing Adverse Selection

Questions to Consider:
1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

Because the only way to access the federal subsidy would be through the Exchange, it is possible that the Exchange will be the de facto market for the uninsured. Therefore, in order to ensure as little market disruption as possible, it may be advisable to allow the continued existence of an individual market external to the Exchange as an alternative for persons who may not be seeking or needing subsidies. Market and Exchange enrollment experience could guide future decisions to combine the Exchange and external markets. To make the decision to combine the two markets at the outset has the potential for creating even greater volatility in the market.

2. What other mechanisms to mitigate "adverse selection" (*i.e.* requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

In order to avoid adverse selection, Illinois should ensure that plans sold outside the Exchange not act to undermine Exchange enrollment by offering plan types that would attract potential Exchange applicants through significantly skewed pricing or benefit structures.

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

To ensure a smooth transition to an Exchange format, IHA would recommend establishing minimum requirements as required by the ACA to allow the Exchange to facilitate consumer choice and enrollment and not act as a purchaser of commercial health insurance plans. While as of yet untested, this type of system would most closely mirror the Utah model.

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?
In order to avoid adverse selection, Illinois should ensure that plans sold outside the Exchange not act to undermine Exchange enrollment by offering plan types that would attract potential Exchange applicants through significantly skewed pricing or benefit structures.

5. What rules (if any) should the State consider as part of establishing the open enrollment period?

IHA recommends the Exchange should limit enrollment periods to minimize the potential for adverse selection. The initial enrollment period should be open for at least six months to take full advantage of providing coverage of uninsured individuals. To balance the concerns of adverse selection with the need to decrease the number of uninsured, yearly enrollment should be

divided into two semiannual open enrollment periods; the first running from mid-May to the end of June with coverage becoming effective July 1. The second would run from mid-November to the end of December with coverage becoming effective January 1. Special enrollment periods should be established that use the requirements established by HIPAA and state continuation requirements for group health plans as a platform, but tailored for persons losing prior individual coverage.

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

Efforts should be made to ensure that any adjustments made both ensure a favorable market in order to lure insurers to participate in the Exchange, and are minimally invasive in order to allow market forces to guide the healthy regulation of the open market. It may be that with the proper establishment of the Exchange, the use of such adjustments might be unnecessary except in circumstance of extreme imbalance of risk.

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

While IHA does not take a position on the specifics of this issue, ensuring a commercial market outside of the Exchange should serve to placate concerns of producers.

IV. Structure of the Exchange Marketplace

Questions to consider:
1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

The choice of either of these schemes should not affect how providers interact with consumers or payers. Still, IHA can see where combining these two markets may be necessary to ensure a sufficient population to establish a risk pool.

2. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

IHA believes the likelihood for success of the Exchange will depend on establishing a limited and orderly transition to the ACA requirements. Therefore, while the Exchange will have to accept groups of 100 in 2016, the current definition of small group in Illinois should be maintained until the Exchange is operational and has demonstrated the capacity to take on greater responsibilities.

3. Should Illinois consider setting any conditions for employer participation in the shop Exchange (*e.g*. minimum percent of employees participating, minimum employer contribution)?

IHA believes that the Exchange should not be involved with making such determinations unless market forces show that coverage that otherwise would be available is being denied to employer groups.

4. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

It is best to leave this decision to a future date in order to assess the market effects of the Exchange. The Exchange should not commit up front to making decisions that could either affect the smooth running of either the Exchange market or the external large group market.

5. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

For efficiency purposes, the state should work through a single Exchange that recognizes the limitations on payers' service areas and provider networks just as the commercial market works today. Multi-state Exchanges should be considered only after the establishment of the state Exchange and with enough risk experience to guide the decision to expand the Exchange.

V. Self-Sustaining Financing for the Exchange

Questions to consider:
1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

Assessing insurers is the most obvious option for funding, but how far afield to cast the net for such an assessment will need to determined based on actual experience.

2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

Whatever the source of funding, it is imperative that any state fund for the administration of the Exchange should be statutorily protected from use for other state funding purposes.

3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?
Given current state budget constraints, it will be difficult to justify diverting funds from existing uses to independently fund existing state mandates. IHA has submitted comments to the Secretary recommending that the definition of essential benefits be broad enough or flexible enough to encompass existing state mandates.

VI. Eligibility Determination

Questions to Consider:

1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

For health reform to achieve its potential, it is critical that the enrollment process be simple and easy for consumers. The state should ensure the electronic enrollment platforms for enrollment in Medicaid and CHIP are developed in such a way to minimize disruption in 2014. Consideration should also be given to ensure that persons who are used to the traditional venues for enrolling in Medicaid and other federal and state assistance programs are not forced into an unfamiliar arena to enroll in these programs.

To assist enrollees, the ACA requires an Exchange to establish a program under which it awards grants to qualified entities to carry out defined education of individuals and facilitate enrollment in qualified plans. IHA recommends that hospitals wishing to act as navigators should be awarded such status based on the fact that they are often the first contact point for uninsured persons seeking medical care.

2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

Uninsured individuals needing health services, whether through Medicaid or an Exchange health plan, should have similar coverage and similar access to providers. To achieve this goal, the Medicaid provider rates will need to be comparable to the provider rates negotiated by the private plans offered on the Exchange. However, given the importance of having an adequate network of providers, the state should be careful not to use Medicaid reimbursement rates, which are already low, as the floor for the rates in the Exchange.

In addition, current Illinois law already has protections for persons covered by an HMO who lose access to their provider due to the provider leaving the HMO's network. Section 25 of the Managed Care Reform and Patient Rights Act (215 ILCS 134/25) establishes time frames for continuing to see a provider under these circumstances given the provider's acceptance of various terms, including accepting the plan's established applicable reimbursement rates. We believe that such transition language could be used as a starting point for drafting language that would help ensure continuity of providers when persons transitioning out of Medicaid into a commercial plan when the Medicaid provider is not part of the plan's network.

3. What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

Because hospitals are key economic engines for Illinois communities, generating not only hundreds of thousands of jobs but also billions of dollars for the state's economy, it is critical during this transition, that hospitals have flexibility to sustain current operations, while

simultaneously taking steps to re-align, integrate with other providers, and better coordinate care, in accordance with an expected plethora of new federal rules. The State must resist establishing rigid requirements that impair these efforts. The State should also provide for periodic evaluations of new arrangements and requirements, to allow for mid-course corrections that reflect what is learned by early adopters of new delivery and payment systems.

In addition to the concepts of a "medical home" (where each patient receives primary care and management of overall care to address chronic conditions and promote wellness), and bundling (where the payment for an "episode of care" is to be distributed among various providers in different settings, such as the physician's office, the hospital, and the nursing home, in an effort to increase patient care coordination among providers), another health reform model that is being promoted is the Accountable Care Organization (ACO). Entering into ACO agreements would enable groups of health care providers to become jointly responsible for a population of assigned Medicare patients, and to share in savings realized from higher quality and lower cost patient care. In theory, this model can also work outside the Medicare arena as well to assist in coordinating payments across commercial and public coverage. IHA supports the ACO concept as a key framework upon which to build collaboration and efficiencies and will work with its members, the state and other interested parties to implement ACOs.

4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

Assessing the need to establish a Basic Health Plan should be predicated on whether the minimal requirements of the Exchange are not fully capturing the needs of the uninsured population. With experience, it may very well be that the increased coverage options currently anticipated by the ACA will create adequate avenues for coverage.

IHA looks forward to working with you and the Council to meet the challenge of establishing a viable Exchange and to ensure the successful enactment of the ACA in Illinois. If you have any questions about our comments, please contact Bill McAndrew, Senior Director, Finance, at bmcandrew@ihastaff.org or (217) 541-1179.

Sincerely,

Howard A. Peters III
Executive Vice President